

University of Wollongong

Research Online

Senior Deputy Vice-Chancellor and Deputy Vice-Chancellor (Education) - Papers Senior Deputy Vice-Chancellor and Deputy Vice-Chancellor (Education)

2010

Mobile asylums: Psychopathologisation as a personal, portable psychiatric prison

Valerie Harwood

University of Wollongong, vharwood@uow.edu.au

Follow this and additional works at: <https://ro.uow.edu.au/asdpapers>



Part of the [Arts and Humanities Commons](#), and the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Harwood, Valerie: Mobile asylums: Psychopathologisation as a personal, portable psychiatric prison
2010.
<https://ro.uow.edu.au/asdpapers/152>

Research Online is the open access institutional repository for the University of Wollongong. For further information contact the UOW Library: research-pubs@uow.edu.au

Mobile asylums: Psychopathologisation as a personal, portable psychiatric prison

Abstract

Psychopathologisation, broadly understood as processes that lead to the effects of being psychopathologised, can have considerable consequences for isolating students from education. This can be especially the case for children and young people affected by the racialization of behaviour and/or socio-economic disadvantage. Drawing on Foucault's analysis of the relationship between the psychiatrist and the asylum in his lectures 'Psychiatric Power', the argument is made that these effects can be tantamount to being institutionalised in a mobile asylum. Portrayal of the asylum in the American television series House MD is used to highlight how, if we rely on classic depictions of the asylum-psychiatrist couplet, we risk missing - or minimizing, the mobile asylum that some young children experience when they are psychopathologised in schooling.

Disciplines

Arts and Humanities | Social and Behavioral Sciences

Publication Details

Harwood, V. (2010). Mobile asylums: Psychopathologisation as a personal, portable psychiatric prison. Special Issue, Discourse, Studies in the Cultural Politics of Schooling, 31(4), 437-451.

Mobile asylums: Psychopathologisation as a personal, portable psychiatric prison

Valerie Harwood*

Faculty of Education, University of Wollongong

Psychopathologisation, broadly understood as processes that lead to the effects of being psychopathologised, can have considerable consequences for isolating students from education. This can be especially the case for children and young people affected by the racialization of behaviour and/or socio-economic disadvantage. Drawing on Foucault's analysis of the relationship between the psychiatrist and the asylum in his lectures 'Psychiatric Power', the argument is made that these effects can be tantamount to being institutionalised in a mobile asylum. Portrayal of the asylum in the American television series *House MD* is used to highlight how, if we rely on classic depictions of the asylum-psychiatrist couplet, we risk missing - or minimizing, the mobile asylum that some young children experience when they are psychopathologised in schooling.

Psychopathology, asylums, behaviour problems, Foucault, history of medicine

Introduction

Cut to the Mayfield Psychiatric Hospital parking lot. Dr Nolan is leaving. He pulls out his car keys and sees House sitting on a railing close to his car.

Dr Nolan: Not the most exciting use of the overnight pass I've ever seen.
House: She left.
Dr Nolan: And ...
House: I'm lost.
Dr Nolan: [*Sits next to House*] I'm going to write your letter ... to the medical board, recommending that they give your license back.
House: You can't just console me by giving me a lollipop when I skin my knee.
Dr Nolan: Well, two things just happened. You got hurt, which means you connected to someone else strongly enough to miss them. And more important ... You recognized the pain and came to talk to me, instead of hiding from it in the Vicodin bottle. The fact that you're hurting and you came here, the fact that you're taking your meds and we're talking right now ... Come inside and get some sleep. Tomorrow you can start saying your good-byes.
[Transcript from *House MD*, Season 6, (Friend, 2009)]

The asylum is the psychiatrist's body, stretched and distended to the dimensions of an establishment, extended to the point that his power is exerted as if every part of the

• Faculty of Education, University of Wollongong, Wollongong, NSW, 2522 Australia.
vharwood@uow.edu.au

asylum is a part of his own body, controlled by his own nerves. (Foucault, 2006b, p. 181)

The centrality of the psychiatrist to the asylum is evocatively portrayed in the above statement by Foucault (2006b). Made during his 1973-74 Lectures at the College de France, the discussion where he offers this remarkable amalgam is concerned chiefly with the desire to account for the 'stamp of medicine' on 'asylum power' (2006b, p. 181).¹ This very same necessity is evident in the depiction of the psychiatrist-asylum couplet in a recent double episode of the television drama *House MD* (Friend, 2009). The dialogue provided above is one of several scenes with interactions between new patient, Gregory House, and chief psychiatrist, Dr Nolan. Throughout this medical drama the power of the psychiatrist is evocatively aligned with the asylum in such a manner that the two are veritably indistinguishable.² Portrayal of the psychiatrist and asylum in *House MD* echoes Foucault's analysis of the two, even though this was directed toward the asylums of the 19th century. This representation, with its uncanny capturing of Foucault's historical sketch of the asylum is exactly my point of departure in this essay.³

My intention is to mount the argument that psychopathologisation can result in confinement in a mobile asylum. From this perspective asylums do not exist only where there are walls, locked doors and where the long held identifiable systems of incarceration and domination prevail. While internment in a recognisable asylum was a pre-eminent feature in the depiction of House's madness, what I hope to outline is how for children and young people, a mobile asylum can arise. Though speculative, this essay seeks to respond to an uncomfortable doubt that arose in recent research into psychopathologisation and disadvantage. Psychopathologisation can be understood as occurring when children and young people experience being subjected to the truth and power of psychopathology (Harwood, 2004). Existence of psychopathologisation is evident in the diagnosis (or suspicion) of a mental disorder and via being subject to the array of practices tied to or invoking questions of psychopathology (for instance: medication, exclusion from school, school assessments, attendance at psychiatric or psychological clinics, child welfare, police, juvenile justice). Initially devised for Australia, the study focused on sites in four Australian states where there were both high rates of prescription medications for Attention Deficit Hyperactivity Disorder and significant social and economic disadvantage (Harwood, in press). In these sites key youth services were targeted, and semi-structured interviews were held with youth service professionals.

Troubled by the findings that suggested the extent of psychopathologisation evident in these young people's lives, the study was broadened to include interviews from two locations outside of Australia: in Cambridgeshire England and in the Greater Bay Area of San Francisco.⁴ The youth professionals interviewed in these locations (two in England and three in the US) were working in areas of socio-economic disadvantage that had comparatively high rates of child and youth behavioural problems. In this essay, due to the restriction of space, I have elected to draw exclusively on two stories from one of these interviews. These are stories that compellingly suggest why we might pause to rethink how we understand the asylum.

Asylum walls

The dialogue between Dr Nolan and House that opens this essay is taken from a scene near the end of the two-part movie length episode that launched season six of *House*

MD, the award winning US medical drama televised in several countries worldwide (Wicclair, 2008). In these opening episodes Gregory House (known as 'House'), the main character of the popular series, is voluntarily committed to Mayfield Psychiatric Hospital for Vicodin withdrawal and for delusions. Waking from drug withdrawal, the story unfolds as House fights succumbing to the care of the chief psychiatrist, Dr Nolan. This relationship between the two doctors (one now a psychiatric patient, the other, the psychiatrist) is pivotal because House is dependent upon Nolan's recommendation if he is to return to his career as a medical doctor. However, a problem arises because 'Dr. Nolan refuses to sign a recommendation to the board of medicine saying he is able to return to work', for this reason, 'House resigns to stay at the hospital and get his clearance' (Fox, 2010). In the scene cited in this essay House had just been granted an overnight pass, the purpose of which he had used to visit the woman with whom he'd formed a romantic attachment; but the woman had rejected him. Sitting outside of the hospital, House encounters Dr Nolan, who assesses him favourably, and ushers him 'inside', where he can 'get some sleep'. Returning to the looming architecture of the hospital to 'sleep' conjures a surprising juxtaposition of tranquillity; one synchronised with House's newfound accommodation of his psychiatrist's advice. This linking of asylum building and psychiatrist is a recurring feature of this episode, and invites us to draw together the inseparability of the two.

Mayfield Psychiatric Hospital figures at the epicentre of these episodes. Filming in this fictional hospital took place on site at Greystone Park Psychiatric Hospital in Parisappany-Troy Hills, New Jersey. Originally named the State Asylum for the Insane at Morristown, Greystone Park was opened in 1876 'as a state-of-the-art mental health facility' that covered over 700 acres. Although designed for around 500 patients, in the mid 20th century this number rose to more than 7000 (Santiago, 2009). These numbers reduced significantly in the latter part of the 20th century, with the hospital finally closing its doors to patients in 2007 (New Jersey Department of Human Services, 2007). In the image reproduced below, the iconographic front of the main building is discernable (which also figured in frequent scenes in the two episodes of *House MD*).



Figure 1: Artist's depiction of the proposed State Asylum for the Insane at Morristown, New Jersey, Perspective View⁵, Publication is circa 1850 (A010535 - Images from the National History of Medicine)



Figure 2 Main Building, State Asylum for the Insane at Morristown, Photo circa 1891-1908, Department of Institutions and Agencies, 1876-1965 (New Jersey State Archives, Department of State)

That the hospital exterior is striking goes without saying. The buildings are extensive, indeed, elaborate, and built to the 'distinctive' Kirkbride Plan that was used only in the United States. Named after the psychiatrist Thomas Kirkbride (1809-1883) and designed by the architect Samuel Sloan, Greystone Park incorporates pavilions, using an 'echelon arrangement' with the structure forming a 'linear plan ... made up of short but

connected pavilions, arrayed in a shallow V' (Yanni, 2007, p. 14).⁶ Greystone Park was what Erving Goffman would call a total institution, with an –

... encompassing or total character ... symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors (1961, p. 4).

Within such a mental institution, as Foucault commented referring to Goffman's work, 'a patient ... is placed within a field of fairly complicated power relations' (Foucault, 2000a, p. 356).

The visual spectacle created by filming *House MD* at Greystone Park presents the power of the asylum, one that is intricately bound up with its structure. In these two episodes, the psychiatrist personified by Dr Nolan does not yield. Although challenged by the infamously controlling and conniving House, the message is clear: it is the psychiatrist, accompanied by the mechanisms of the asylum apparatus and underpinned by the quintessential building that triumphs.

This example from the recently screened episode of *House MD*⁷ clearly conveys the powerful way in which the asylum functions as a signifier par excellence for madness and its treatment in our culture. The influence of this architecture is not surprising given the presence of asylum structures over the last 200 to 300 years in western culture, the more recent closures following the publicised de-institutionalisation movements of the mid-20th century (Fakhoury & Priebe, 2007). What Foucault's assessment reminds us of and why it is so valuable, is that it pinpoints the relation *between* the asylum and the psychiatrist as what assures asylum power. When Foucault (2006b) set out to analyse psychiatric practices in these lectures he highlighted the shift made from his previous analyses in the *History of Madness* (Foucault, 2006a). The move is from one focused upon the examination of representations via 'the perception of madness' to an analysis that emphasises power. Concern with psychiatric power in these lectures is reflective of the view that grasping this form of power assists in understanding the mechanisms of normalisation (Foucault, 2000b). Attentiveness to power is an insight that has had a good deal of influence for critical studies into medicine and mental illness (Bunton & Peterson, 1997; Rose, 1989, 1998) and psychiatry (Bolton, 2008), and is one that can assist in the development of another conception of the asylum.

Power, the clinic and token knowledge

The necessity of the relationship between the psychiatrist and the asylum raises a crucial problem for my argument in this paper.⁸ Namely, if Foucault's line of reasoning is adhered to, what is the relation that exists for the mobile asylum (is it between the psychiatrist, or is it more than that individual specialisation?) and does this relationship underwrite the power of the mobile asylum? Contrary to commonplace depictions such as in popular media like *House MD*, in the mobile asylum neither walls nor the sole figure of the psychiatrist are central. Yet, to think of an asylum without walls is to expunge one of its principal features, and to cleave the psychiatrist from a central position could, arguably annul if not reduce the potency of asylum-power. A way forward in the conceptualisation of the mobile asylum is to seize on the weight that Foucault placed on the clinic in these lectures, and to explore how the clinic, envisioned as interconnecting networks of knowledge-power, may constitute a relationship that produces asylum type power.

In his analysis of the specific points at which power is exercised effectively in the asylum, the clinic is identified as *the* fundamental site in the propounding of psychiatric power.

The enormous institutional importance of the clinic in the daily life of psychiatric hospitals from the 1830s until today is due to the fact that the doctor constituted himself as a master of truth through the clinic. (Foucault, 2006b, p. 187)

Here the reference is not restricted to the asylums of history, but right up to the present moment. But what is the clinic? On the one hand, as Long logically concludes, it 'is first a place to diagnose and treat sick persons' (1992, p. 137). It is however more than that, it is 'also a way of thinking and speaking; it is a discursive practice that links health with knowledge' (Long, 1992, p. 137). Combining these it is feasible to challenge the privileged position of the clinic as a site (the doctor's office, for example) and extend it outward. The clinic then could be conceived as a form of power, a network that 'diagnoses and treats sick persons' via the 'discursive practices that links health and knowledge'.⁹ The prominence to the asylum that Foucault attributed to the clinic can be applied to the mobile asylum, even withstanding the sweeping changes that have occurred since deinstitutionalisation. The proposition being, firstly, that in our contemporary moment, and especially with deinstitutionalisation and the increases of community-orientated services, the clinic-mobile asylum may function in lieu of the psychiatrist-asylum. It may well offer a means to conceptualise how the figure of the psychiatrist has been displaced. Secondly, this relationship may well underwrite the power of the mobile asylum.

To conceive of the clinic as not tied to a specific asylum, and yet functioning in a manner that produces mobile asylum power onto children appears unworkable. Turning to the 1973-74 lectures presents a decisive route to establish how such a clinic may operate: 'tokens of knowledge'. These 'the tokens of knowledge are magnified in the clinic ... The tokens of knowledge, and not the contents of science, allow the alienist to function as a doctor within the asylum' (Foucault, 2006b, p. 187). It is, however, what these 'tokens of knowledge' allow, that is essential:

These insignia of knowledge enable him to exercise an absolute surplus power in the asylum, and ultimately to identify himself with the asylum body. These tokens of knowledge allow him to constitute the asylum as a sort of medical body that cures through its eyes, ears, words, gestures and machinery. (Foucault, 2006b, pp. 187-188)

Returning to the problem at the heart of this essay, which is the power of the proposed mobile asylum, it is possible to use this analysis to suppose how a surplus of power might be manifested. Points of analysis from these lectures where Foucault emphasised psychiatric power and how it functions offers a means to theorise the power that acts upon young individuals who are interred in ways that are tantamount to confinement.

In the remainder of this essay my objective to work with this idea of the centrality of the clinic as a means to tease out this notion of the mobile asylum. To do this I draw on two case studies of children described by Nancy, the US interview participant who had considerable expertise and experience in the field of child and youth disability. While this interview does focus on issues in the State of California, the insight to be gained is of consequence in other regions experiencing alarming rates of child and youth psychopathologisation (for instance, the United Kingdom, Australia, Canada and several European countries) (Scheffler *et al.*, 2007). The first case study, describing Elijah's confinement in the family apartment, demonstrates how the tokens of knowledge enable the action of a clinic that can occur between institutions (the

school, the hospital, welfare agencies). In the second case study, the emphasis is on legislation: another form of token knowledge that serves to make a clinic between institutions possible. The aim in presenting these stories is to convey the *effects of power* as these manifested toward and acted upon these two children. The marked difference between these stories and the confinement that occurs in the classic psychiatrist-asylum couplet (as demonstrated in the example from *House MD*) points to the possibility of the existence of the mobile asylum.

The mobile asylum¹⁰

Diagnostic categories¹¹ such as ADHD are tokens of knowledge that are connected to an extensive array of cultural practices of psychopathologisation, many of which are associated with diverse coercive mechanisms. A case in point is the distinction between having ADHD and being ADHD.

There's this shift and I've been hearing it in the last two to three years, where now it isn't that you *have* ADHD, suddenly you are ADHD. I'm starting to hear 'My child's ADHD', not my child *has* it'. (Nancy, Interview).¹²

To be ADHD as opposed to having ADHD is a subtlety that could well pass as nothing more than a slight change in language. How can a child 'be' ADHD, and how can such psychopathologisation be so effective, when, compared to the weight of internment in an institution, it is little more than a diagnostic category? A clue can be found in the tokens of knowledge that are readily available, and make possible, a clinic that can exist between institutions. These tokens of knowledge include far more than categories. While categories have a central role, how these translate into power needs to be carefully investigated. In the cases discussed below, categories lend support to other tokens of knowledge such as pieces of legislation that make it legal to detain children and young people on the basis of the degree of their psychopathology. Because these tokens of knowledge are so readily available and all too straightforwardly applied, internment within the solid walls of one institution is not necessary. A clinic can thus operate between institutions and draw on token knowledge such as categories and legislation that both supports and gives power to these categories. This can operate in ways that can *effect* a production of power that is uncannily like the asylum power synonymous with the psychiatrist-asylum couplet.

A clinic between institutions: Elijah's story¹³

The story of Elijah, a 9-year-old African-American child, offers a poignant example.¹⁴ Elijah's story was told to me in an interview by Nancy who had come into contact with the 9-year old and his 23 year old mother because of considerable difficulties that were occurring in school. Elijah had been sent home by his teacher on 'the very first day of school ... after 30 minutes or so because he's throwing papers and he won't sit down and he's openly defiant'. Psychopathologisation can occur when a teacher speaks of a child 'having behaviour problems'. In this instance, whilst an official diagnosis is not conferred, the spectre of diagnosis is raised (Harwood, 2006). Attribution of diagnostic categories does more than invoke an allusion to something that is of little consequence because it is purely speculative, or even an aside in a school staffroom. To assume that there are no effects without diagnosis is to miss the power of psychopathologisation (Harwood, 2006; in press). When a child is spoken of as having a mental disorder, these

words could come from a number of people, some are associated with institutions such as schools, clinics, hospitals, family drop-in centres and others are not. They may be in line at the supermarket, in the family, friends, other children, or in the media. When commenting on a child's behaviour, this could possibly function as token knowledge, that given the action of power, could have the propensity to contribute to the psychopathologisation of a child that in some instances could result in what is, in effect, a mobile asylum.

In Elijah's case, the teacher that suspected psychopathology was in her first year of teaching, and Nancy commented on how she sympathised with the difficulties that the teacher faced in a 'room full of kids'.¹⁵ One day when he threw paper and ran from the room refusing to do as asked, the school sent Elijah for psychiatric evaluation at the Children's Hospital. The hospital did not detain Elijah, since according to their assessment 'he's not a danger to himself or others, so therefore doesn't meet the criteria that would allow us to keep him involuntarily here at the hospital' (Nancy interview). The hospital did recommend, however, that he could benefit from assessment for special education.

Assessment for access to special education provisions required Elijah's mother to complete a questionnaire. Nancy explained that when 'mum is filling out a questionnaire about her child, she feels like the school already hates her child, they think he's a horrible child, so she minimizes all his behaviours at home'. Based on the mother's responses, Elijah did not satisfy the requirement of being 'cross context', which meant he did not qualify for special education. This led to the decision that Elijah had social maladjustment, which 'is not the same as disability, it is cultural or socio-economic' (Nancy interview). Failure to qualify for special education provision meant the school refused Elijah entry, and he ended up out of school for several months. With the school refusing to have Elijah, and being a single mother who needed to work, there was little else to do but leave her son at home. She did her best and organised for Elijah to have the phone number of a neighbour in case of any emergencies. School days were spent like this, for several months on end: day after day, at home in an apartment, while his mother went to work to support them both.

John, a hospital social worker, was in contact with Elijah and his mother, and reported to Nancy that the young boy was now 'horribly depressed and suicidal' (Nancy interview). He had contacted Nancy, to inform her that he had 'diagnosed Elijah with ADHD and ODD (Oppositional Defiant Disorder)¹⁶, because "I've gotta give him a label cause I've gotta get him some help"' (Nancy interview). As she recounted, John had expressed exasperation because 'Elijah's been on waiting lists to get these medical assessments that the school said he had to get' (Nancy interview). With ADHD and ODD, Elijah was eventually given a behavioural support plan, and access to a psychologist, and, as Nancy pointed out, 'there will be immense pressure on mum to medicate him'. As these psychopathologising interventions proceeded, the school principal commented to Nancy that 'part of the problem might be that he's kinda bored "cause he tests high school on his verbal"' . Nancy had reviewed the behaviour checklists completed by the classroom teacher, and on 'every single thing he was the most extreme worst case'. Armed with this information, Nancy questioned the teacher, asking her, 'Is there nothing likeable about this child? Is he Satan? Because when you read this you would think Satan has come to your school'. The teacher's response to this question was that they didn't really know Elijah, because 'he's never lasted more than 30 minutes in my classroom'. Nevertheless, Elijah was barred from school and confined to the family apartment.

Elijah was in a mobile asylum. When he had attended school, he was taken from that school to a Children's Hospital for psychiatric evaluation. He spent four months at home, alone. Days were lived in an apartment with no access through the boundaries of the school. Later, when he was not permitted to attend school, he had been assessed by a social worker, which led to the diagnosis with ADHD and ODD. Elijah was later put on a behaviour support plan and allocated a psychologist. Next he was a candidate for referral to a more restricted school, and there was the spectre of medication (alongside the practices medication routines). The isolation endured by Elijah appears to be the obvious point at which the asylum appears, and in this respect there is the risk of attributing the asylum on the basis of the presence of walls. However, this would be to err on an analysis that emphasises the *perception of madness*. In this case, this means recourse to recognisable representations of the asylum. Relying on the apartment as the indicator of the asylum additionally could lead to overlooking the effects of what Priebe (2004), drawing on Goffman (1961), terms 'institutionalisation without walls'. This form of institutionalisation can be identified in community populations of psychopathologised¹⁷ adults where for example assertive outreach services 'can develop phenomena of institutionalization such as forms of persistently bizarre interactional behaviour between staff and patients' (Priebe, 2004, p. 81). If Elijah's story is analysed from the standpoint of power, the effects of institutionalisation can be witnessed both within and outside of the apartment. It is this surplus of power generated by the clinic-mobile asylum (and not the psychiatrist-asylum) that came to affect Elijah, preventing him from attending school and confining him to solitude in the family apartment.

As Elijah's story demonstrates, the surplus power of the clinic can directly act on a young person, causing them to be interred in new ways. For Elijah, the token knowledge of his suspected psychopathologisation led to his confinement, and this occurred independently of an asylum such as Greystone Park Psychiatric Hospital. From one angle, it could be maintained that he was excluded from school, and not confined. Although this interpretation is correct, because it does not seek out power, it misses assessing the effects of what can so easily pass as only exclusion from classes. The danger of this assessment is that Elijah's very real and very distressing experience of confinement remains invisible. Calling upon the idea of the mobile asylum permits a view that has the potential to ascertain the workings of power, and thereby more closely appreciate the experiences of this child.

The token knowledge of 5150 legislation: Martin's story

The power that produces the mobile asylum relies on many elements, the foremost of which is the diagnostic category. These categories are not only significant as token knowledge to be applied to an individual. In Elijah's story, the spectre of behaviour, and the recourse to diagnosis loomed large. When he wasn't diagnosed due to the lack of 'cross context' the effects were stultifying, with his banishment from school and the consequent virtual incarceration in the family apartment. When he was diagnosed he moved from the apartment and into psychological treatment and educational remediation, with both serving to inscribe psychopathology. Although forming an integral token knowledge that can be directly applied, these categories also inform a range of contemporary practices, such as schooling provision and legislation for psychiatric intervention.

Elijah's story draws our attention to power, provoking reconsideration of the form an asylum can take and where it may occur. The second story is concerned with the operation of power again; but this time, power that was wielded via recourse to the

token knowledge of legislation. The token knowledge of this legislation formed part of the rationale that led a principal to use a SUV (sport utility vehicle) to give chase to and contain a Martin, a 6-year-old African American child. Martin had been sent to the principal's office.¹⁸ In this office, when he was told that his mother was being called, Martin ran out, running from the school into the busy neighbourhood and down a busy road. The principal, together with his secretary, for reasons of concern, quickly sought to follow the boy. They got into 'this big, black SUV, he's a white principal, big guy, and he's chasing after this little kid' (Nancy interview). When they did get to Martin they tried to pull him into the SUV. The effort to pull him into the vehicle resulted in Martin becoming bruised, an indisputable fact evidenced by the photos taken by his mother after the incident.

Deciding 'he's a danger to himself', the two school personnel called the police. A 5150 is the term for a piece of legislation contained in the State of California's Welfare Institutions Code. This legislation authorizes involuntary incarceration under psychiatric care, for a period of up to 72 hours. The code depends on two conditions; the identification of a mental disorder and that the individual with this disorder 'is a danger to others, or to himself or herself, or gravely disabled' (California Law). The Code allows for a 'peace officer' or authorised psychiatric staff (of the institution or, for example, a mobile crisis team) to take the individual into custody for a period of 72 hours in order to provide for evaluation and treatment. When the 'peace officers', the police, arrived, they proceeded to take the young boy into custody. Mistakenly, the frightened child was relieved, believing that the police were there to help him. To the child's surprise, the police handcuffed him explaining that this was the official procedure. In the report on the incident the police made positive comments about the child, which Nancy described as something to the effect 'the child was very agreeable and compliant to everything that I asked him to do'. The child was handcuffed, even though the police car had a protective screen, and the report states that the child was 'compliant'. Nancy was of the view that 'I would not have believed that they would have handcuffed a white child in a suburban school'.

Handcuffed, the child was taken by police vehicle to the Children's Hospital for psychiatric assessment. After two to three hours in the hospital the staff decided that 'while he may have ADHD or something like that, there isn't any reason to hold him'. Although he was sent home, the school did not permit him to return, stipulating that he was not safe there, because he 'ran off'. The boy was put on a '45 day interim placement while they figure what to do' (Nancy interview). Over this period the school organised 'one hour per week of home instruction'. The mother, 'who was the only breadwinner' and had 'other children' ended up losing her job. At the same time, the Children's Hospital continued to assess the child, investigating possible diagnoses. As with Elijah, these were the pathway to returning to school since it would provide for special education funding provision. Medication was also likely to accompany the diagnosis, even though, as Nancy points out, 'parents don't ever seem to be told that the medication doesn't seem to have any impact on learning ... parents are willing to medicate because maybe he will do better at school'. Two instances of token knowledge tied to the category are apparent: the connection between diagnosis and special education provision, and with medication. Both Elijah and Martin were barred from their schools and both were subjected to diagnostic processes with the purpose to establish a disorder. The presence of which would secure the funding support that was demanded by the schools to allow the children to return to class.

Martin would not, according to Nancy, have been put on the interim placement order had the family had 'significant financial resources'. If that had been the case,

‘there would have been a placement’. Nancy, and the other child and youth professionals interviewed in the study indicated that children from racial minorities and/or poor backgrounds had markedly different experiences in relation to perceived behavioural problems (Harwood, in press). It is not an accident that both of the stories told by Nancy were of black children: there is much cause for concern regarding the racialisation of diagnosis, with black children over-represented in the special education classroom (Ferri & Connor, 2005; Fitzgerald, 2009). Evaluating these experiences as instances of a ‘mobile asylum’ affords countenance of the institutionalising – and racializing effects that may be occurring. Recalling the insights from Goffman’s (1961) *Asylums*, it is wise to remember that behaviours that would appear to belong to madness are arguably the product of institutionalising effects.¹⁹ Following Goffman then, there are very real *institutionalising effects* occurring for children such as Elijah and Martin confined in their own home. These effects can be missed if the asylum and institutionalisation are not recognised.

Confinement within one institution did not occur for Elijah and Martin. At least, not in the way that confinement and internment in traditional asylums are understood, whether from the 18th century of Foucault’s analysis, or from the 20th century of Goffman’s famous sociological study. Broadly speaking, these asylums were a distinct entity, and the inmates belonged to, and were identified with, a singular institution. Whether it be the Bicêtre of Phillipe Pinel in late 18th century Paris, or the Washington mental institution in the ethnography by Erving Goffman in the mid-20th, the asylum held true as a rigid structure. Although the apartments that the boys were contained within had a rigid structure, the walls that held them are not analogous to the asylum-psychiatrist couplet described by Foucault and so aptly portrayed in *House MD*. Nor can the apartment be considered as an asylum in and of itself. Neither Elijah or Martin were ‘free’ once they could move beyond those walls, for they remained very much subject to the token knowledge of a clinic, albeit one that seems somewhat intangible compared to the clinic that is easily perceptible in the asylum setting. This clinic that administers a power that can produce the mobile asylum can position children with mental disorders, and effectively prevent school attendance. This clinic operated between institutions, ensuring that confinement did not cease with movement out of an apartment. This suggests the importance of a distinction between the ‘institution without walls’ proposed by Priebe (2004) and the mobile asylum. More than institutionalisation happened to the children: they were physically blocked, prevented from entering places. Their movements were restricted, and these impositions were particularly effective by virtue of their status as children, where their choices were drastically closed down.

Conclusion: A case for the mobile asylum?

Integral to the function, indeed the identity of the asylum, is the type of power; a power intimately controlled by the ‘psychiatrist’s nerves’ (Harwood, 2006), and that produced the psychiatrist-asylum. The asylum, portrayed to stereotype in *House MD*, is surrounded by walls and contains a plethora of recognisable idiosyncrasies. It is a place characterised by the enmeshing of architectural boundaries with the psychiatrist’s all-knowing persona. While some grandiose asylum structures remain, and some feature in popular broadcasts that serve to enshrine the psychiatrist-asylum couplet, it would be mistaken to believe that asylums exist solely in this form. To contend the existence of a mobile asylum is to depart from this evocative image, and to look instead to the exercising of power that can produce asylum type effects. The stories of Elijah and Martin reveal certain powerful practices that deserve reconsideration.²⁰

There is, however, a response to be made to an invisible interlocutor who would be more than justified to ask, ‘why asylums?’ The rationale for this choice is twofold. First, what might be missed if we assume a tidy demarcation between psychopathologisation of child behaviour and what Erving Goffman (1961) called the ‘total institution’? Would the latter exist to serve a relational purpose of extremity, symbolic of the sobering finitude of mental disorder? Second, has the emphasis that has continued to be placed on the asylum as the marker of the extreme cause us to be unaware of the extremes that can and do exist via the psychopathologisation of child behaviour?

For this reason it is crucial to revisit the orthodoxy of the asylum. This requires a shift in focus from the perception of madness (for instance, the ADHD child) to one concerned to interpret the effects of power. To argue for the mobile asylum is to argue for the need to be alert for and recognise power and the frightening effects that certain practices, regardless of their intent, can engender. If the psychiatrist-asylum couplet is challenged we may well be better positioned to appreciate the workings of a power that can confine children and young people. The psychiatrist is no more orchestrating from a site positioned above and beyond us than the asylum is the only place to which the psychopathologised are confined. In our contemporary experience of psychopathologisation, the asylum as motif of madness needs to be re-evaluated. It can no longer be identified by distinction from the world of the everyday, but rather, by its faint assimilation amongst us.

Acknowledgements

My thanks to the editors of this special issue, Anna Hickey-Moody and Vicki Crowley, for their kind support of this paper. My thanks also to the two universities that hosted me during my sabbatical in 2008: The Beatrice Bain Research Group, University of California, Berkeley, and the Department of History and Philosophy of Science, University of Cambridge.

Notes

- ¹ This discussion occurs in Lecture Eight, 9 January 1974.
- ² For a fascinating discussion on the increasing use of biologically based interpretations of the mind in literature see Marco Roth’s (2009) essay *The rise of the neuronovel*.
- ³ For a discussion that departs from Foucault’s account of the rise of the asylum and the psychiatrist see Wright (1997).
- ⁴ Details of the locations have been altered to maintain confidentiality. Due to budget constraints the international site selection was made to reflect the original aims of the project (to investigate the occurrence of the high diagnostic rates of behavioural disorders in areas of disadvantage) and to coincide with the locations where the author took sabbatical leave in 2008 (University of California, Berkeley and University of Cambridge).
- ⁵ The name was changed in 1925 to New Jersey State Hospital at Greystone Park, and it was later known as Greystone Park Psychiatric Hospital. This image is sourced from the *Images from the History of Medicine*, United States National Library of Medicine, National Institutes of Health. The image is estimated to be circa 1850. It is a depiction of the building, and was reproduced in the *Report of the Commissioners Appointed to Select a Site and Build an Asylum for the Insane of the State of New Jersey* (1872).
- ⁶ The Kirkbride Plan was based on ‘moral treatment’ of the insane, an approach that was enthusiastically endorsed by Thomas Kirkbride (Yanni, 2007). Moral treatment, developed in the late 18th century, and popularised in the 19th, departed from what was viewed as punitive and cruel treatment of the insane. The approach stresses ‘respectful and kind treatment under all circumstances, and in most cases

-
- manual labor, attendance on religious worship on Sunday, the establishment of regular habits and of self control, diversion of the mind from morbid trains of thought'. (Brigham, 1847, p. 1)
- ⁷ Premiered in the US, 21 September 2009. Screened in Australia 31 January 2010.
- ⁸ The argument in this essay has benefited from the contributions and criticisms made by the two anonymous reviewers. My thanks for their input.
- ⁹ See also my discussion of biopower and biopedagogies (Harwood, 2009b).
- ¹⁰ This discussion is tentative, and is presented as a first attempt to theorise the power that can confine and detain psychopathologised children.
- ¹¹ Mental disorders such as ADHD defined are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). Disorders that are associated with behaviour problems can include, but are not restricted to ADHD, Conduct Disorder, Oppositional Defiant Disorder. With the application of the concept 'co-morbidity', terms may also include such disorders as Bipolar Disorder (Masi *et al.*, 2006) or depression (Brown, 2008).
- ¹² From an interview conducted by the author in 2008. All names and identifying information has been changed.
- ¹³ The stories of Elijah and Martin are challenging because of the issues that they convey. The re-telling of these stories by Nancy could be questioned for its veracity, and to what extent it can be taken as plausible. My view is that these stories, from a highly respected professional who has developed close contact with and the respect of the individuals with whom she works, are valuable and are significant. In this sense, both Nancy's re-telling of these stories, and my own attempt to present them here, is an effort 'to prick the consciences of readers by inviting a re-examination of the values and interests undergirding certain discourses, practices, and institutional arrangements found in today's schools'. (Barone, 1992, p. 143)
- ¹⁴ All names and potentially identifying material has been altered or removed.
- ¹⁵ Preservice teachers and newly qualified teachers rate behaviour problems as a high cause for concern (McMahon, 2008; McMahon, in press), a point that deserves careful attention if the issue of speculating about behaviour problems and the associated psychopathologisation is to be addressed.
- ¹⁶ Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD).
- ¹⁷ The phrase 'psychopathologised adults' is used to displace the emphasis *from* the individual as having a mental disorder and *to* the processes that identify them.
- ¹⁸ While from the perspective of the principal and his secretary, the rationale for giving chase to Martin may appear sound, the point here is to bring to the fore the power that enabled this to occur, particularly the suspicion that Martin was a danger to himself and may need to be in psychiatric care. This suspicion, and the possibility that it could be acted on was only possible because of the 5150 legislation.
- ¹⁹ This is a point that deserves to be further explored empirically, since it could add a valuable perspective on institutionalising interpretations of child and youth behaviour. This is especially important from the point of view of the mobile asylum. For example, how might behaviour be differently understood if the institutionalising effects of the mobile asylum are taken into account?
- ²⁰ While these two stories are from the US, given the accounts from the participants in the Australian interviews, previous research by the author, together with anecdotal evidence, it is likely that comparable stories exist in Australia and elsewhere. This is an area that could benefit from further research with children and their families.

References

- A010535 State Asylum for the Insane at Morristown. Images from the History of Medicine, United States National Library of Medicine, National Institutes of Health, Image Retrieved on 4 May 2010 from <http://ihm.nlm.nih.gov/luna/servlet/view/search?q=A010535>.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (4th ed.). Washington DC: APA.
- Barone, T. (1992). Beyond theory and method: A case of critical storytelling. *Theory into Practice*, 31(2), 142-146.

- Bolton, D. (2008). *What is mental disorder? An essay in philosophy, science and values*. Oxford: Oxford University Press.
- Brigham, A. (1847). The moral treatment of insanity. *American Journal of Insanity*, 4(1), 1-15.
- Brown, T. E. (Ed.). (2008). *ADHD Comorbidities: Handbook for ADHD complications in children and adults*. Arlington: American Psychiatric Publishing.
- Bunton, R. & Peterson, A. (1997). Foucault's medicine. In R. Bunton & A. Peterson (Eds.), *Foucault, health and medicine* (pp. 1-11). London: Routledge.
- California Law. Welfare and Institutions Code, *Section 5150* Retrieved 2 November 2009
<http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=5431285642+0+0+0&WASAction=retrieve>.
- Department of Institutions and Agencies. (1876-1965). *New Jersey State Hospital at Greystone Park Annual Reports, 1876-1965*. State of New Jersey.
- Fakhoury, W. & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, 6(8), 313-316.
- Ferri, B. A., & Connor, D. J. (2005). In the shadow of brown. *Remedial and Special Education*, 26(2), 93-100.
- Fitzgerald, T., D. (2009). Controlling the Black School-Age Male. *Urban Education*, 44(2), 225-247.
- Foucault, M. (2000a). Space, knowledge, power. In J. D. Faubion (Ed.), *Power, the essential works of Michel Foucault* (Vol. III, pp. 349-364). New York: The New Press.
- Foucault, M. (2000b). Truth and juridical forms. In J. D. Faubion (Ed.), *Power, the essential works of Michel Foucault* (Vol. III, pp. 1-89). New York: The New Press.
- Foucault, M. (2006a). *History of madness* (J. Murphy & J. Khalfa, Trans.). Abingdon, Oxon: Routledge.
- Foucault, M. (2006b). *Psychiatric power: Lectures at the College de France 1973-1974*. New York: Palgrave Macmillan.
- Fox. (2010). *House MD*. Retrieved 1 February 2010, from
http://www.fox.com/house/recaps/s6_e01.htm
- Friend, R. (Writer of TV series) (2009). House MD - 6.02 Broken, part 2, *House MD*. US: Fox.
- Goffman, E. (1961). *Asylums, essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Harwood, V. (2004). Subject to scrutiny: Taking Foucauldian genealogies to narratives of youth oppression. In M. L. Rasmussen, E. Rofes & S. Talburt (Eds.), *Youth and sexualities: Pleasure, subversion and insubordination in and out of Schools* (pp. 85-107). New York: Palgrave.
- Harwood, V. (2006). *Diagnosing 'disorderly' children: A critique of behaviour disorder discourses*. London: Routledge.
- Harwood, V. (in press). The new outsiders: ADHD and Disadvantage. In L. J. Graham (Ed.), *(De)Constructing ADHD: Critical guidance for teachers and teacher educators*. New York: Peter Lang
- Long, J. C. (1992). Foucault's clinic. *The Journal of Medical Humanities*, 13(3), 119-138.
- Masi, G., Perugi, G., Toni, C., Millepiedi, S., Mucci, M., Bertini, N., et al. (2006). Attention-deficit hyperactivity disorder - bipolar comorbidity in children and adolescents. *Bipolar Disorders*, 8(4), 373-381.
- McMahon, S. (2008). Ready and rearing to diagnose: A study of preservice teachers' response to and participation in discourses of ADHD in school settings. Unpublished Honours thesis, University of Wollongong.
- McMahon, S. (in press) Doctors diagnose, teachers label: The unexpected in pre-service teachers' talk about labelling children with ADHD. *International Journal of Inclusive Education*.

- New Jersey Department of Human Services. (2007). *A new beginning: Greystone Psychiatric Hospital, 2nd Ed.*
- Priebe, S. (2004). Institutionalization revisited - with and without walls. *Acta Psychiatrica Scandinavica*, 110, 81-82.
- Rose, N. (1989). *Governing the soul, the shaping of the private self*. London: Routledge.
- Rose, N. (1998). *Inventing ourselves: Psychology, power, and personhood*. Cambridge: Cambridge University Press.
- Roth, M. (2009). The rise of the neuronovel, *n+1*, Vol. 8, October 19 Retrieved January 28 2010 from <http://www.nplusonemag.com/rise-neuronovel>.
- Santiago, K. (2009, 14 April). TV show 'House' to film at Greystone Park Psychiatric Hospital. *The Star-Ledger*.
- Scheffler, R. M, Hinshaw, S. P., Modrek, S., & Levine, P. (2007). The global market for ADHD medications: The United States is an outlier among developed countries in its high usage rates of these medications among children. *Health Affairs*, 26(2), 450-457.
- Wicclair, M. R. (2008). Medical paternalism in House M.D. *Medical Humanities*, 34(2), 93-99.
- Wright, D. (1997). Getting out of the asylum: Understanding the confinement of the insane in the nineteenth century. *Social history of medicine*, 10(1), 137-155.
- Yanni, C. (2007). *The architecture of madness: Insane asylums of the United States*. Minneapolis: University of Minnesota Press.